in four females and two males. Chorea from other causes is also more frequent among females than males.

The diagnosis depends upon the history of the case, apparent evidences of syphilis, and absence of other causes, as rheumatism, heart disease, etc. The movements also seem to be more spasmodic and less continuous than in ordinary chorea.

The prognosis depends, as in other syphilitic diseases of the nervous system, upon the time the constitutional affection is discovered, the earlier the more favourable.

Some form of mercury alone or combined with potassium iodide promises the best results in those cases occurring in the early stages of the constitutional disease; and the iodide alone pushed to large doses in the later stages.

ARTICLE V.

TWO CASES OF CATARRHAL INFLAMMATION OF THE BLADDER, RESULTING IN THE PLUGGING OF ONE URETER AND THE FORMATION OF CHEESY MASSES IN THE KIDNEY; DEATH FROM ACUTE TUBERCULOSIS.

By MORRIS LONGSTRETH, M.D., Pathologist to the Pennsylvania Hospital; Lecturer on Pathological Anatomy at the Jefferson Medical College.

THE two cases, which form the basis of this paper, present a comparatively rare pathological picture; they give a striking confirmation of the dependence which an irruption of miliary tubercle has on the previous existence of a cheesy mass in the body. Still further, the cases afford a better explanation than any hitherto given of that form of destruction of the kidney which has received the name of local or primary tubercle (the second form of tubercle described by Rokitansky).

CASE I.—E., æt. 23, died Oct. 26th, 1876. His history is that of impaired health for four or five years. About two years prior to death he contracted gonorrhœa, which was followed by a stricture, and about a year later (Oct. 1875), by inflammation of the bladder. At this time he caught a severe cold and had pleurisy, and from that time forward, his urinary symptoms became steadily worse, up to the time of his death.

Dr. Finn had charge of the case from June, 1876, and at this time the patient was quite thin and evidently suffering considerable pain most of the time. A suspicion of vesical calculus was proved to be unfounded, after a careful examination. There was extreme tenderness over the lower part of the abdomen, especially about the region of the bladder. Micturition frequent (hourly, and sometimes half-hourly). Physical examination did not reveal any evident affection of either kidney. The urine contained pus and abundance of catarrhal products; but no tube-casts or sugar were found. The family history shows no inherited disease. It was impossible to obtain a satisfactory clinical history from the patient himself, and his family were ignorant of the presence of his disease, until a late period of his illness.

For the history of this case, and the opportunity of making the autopsy, I am indebted to my friend Dr. Wm. H. Finn.

Post-mortem Examination.—The body presented but little evidence of emaciation. The *great cavities* of the body showed no appearances of inflammatory alterations. The *heart* was normal. The *lungs* were heavy, congested, and œdematous; crepitation was everywhere present, except at a few places posteriorly. There could be felt pretty generally scattered throughout the lung-tissue, hardened nodules of small size. On section, the lung exuded abundant frothy and bloody serum; the cut surface presented a marbled aspect (catarrhal pneumonia) to a considerable extent, but no characteristic pneumonic solidification. Sparsely scattered in all directions were found numerous grayish granulations of very small size, of firm consistence, giving the surface a quite rough, uneven sensation to the finger. The dense areas at the posterior part of the lungs represented the condition of splenization. The *bronchial tubes* contained a considerable amount of thick, frothy serum; their walls presented no marked changes. The *spleen* and *pancreas* were normal. The *right kidney*, while somewhat swollen in appearance, presented no alteration of its parts; its tissue was quite markedly congested; the right *ureter* and its pelvis were unaltered. The *left kidney* was found very much enlarged, elastic under the finger in places, giving a very doubtful sensation of fluctuation; the *ureter* in all its course was very considerably enlarged, quite firm, with a somewhat uneven surface like an evenly twisted rope. The kidney was very firmly adherent in the connective tissue; the surface was uneven, slightly lobulated, in places appearing of a pinkish-white colour. On section, there were found large blocks of yellowish-white cheesy matter, somewhat quadrilateral in shape, occupying the seat of the pyramids; the pressure of the knife in making the section broke down these masses somewhat, but the areas were not, strictly speaking, softened. This cheesy matter was washed out subsequently by the preservative fluid.

The *bladder* was pretty firmly contracted and its walls were thickened. It contained a small amount of cloudy urine, in which was found a little soft calculous matter, some membranous shreds, and flakes of soft, cheesy-looking material. The mucous membrane was uneven, presented much congestion, and even ecchymosis in irregular patches. No distinct ulcers were found, but the surface was very distinctly softening and separating. The entrance of the ureter was somewhat enlarged, barely admitting the point of the finger, and in the calibre of the tube could be seen quite soft cheesy material, evidently breaking down and in the process of being cast into the cavity of the bladder. The lower end of the ureter was laid open and its surface appeared uneven and somewhat folded, but not ulcerated. The picture was the same as that showed by chronic bronchial inflammation. There was found no evidence of any tubercular deposit, or of isolated tubercle-nodules, either in the mucous membrane of the bladder or of the diseased ureter. The prostate was normal. The glands in the hilum of the left kidney were very much enlarged, of a whitish aspect exteriorly, and of rather soft cheesy consistence internally. There were no other glandular enlargements discovered. The *intestines* presented nothing especial. The *glands of the mesentery* were unchanged. The *liver* was normal.

No special examination of the *testicles* was made; there had been no symptoms referable to them during life, and at the post-mortem examination the scrotum and external parts showed nothing abnormal.

Case II.—W. G. N., æt. 38, single, salesman; admitted to the Pennsylvania Hospital May 9, 1877; died May 14, 1877. His family history shows freedom from inherited disease; and he has enjoyed good health until five months previous to admission, when he caught a severe cold, followed by muco-purulent expectoration and quite a severe attack of hæmoptysis; fifteen other hemorrhages followed in the subsequent three months; his cough increased and he steadily lost flesh.

On admission, the patient is very thin and anæmic; complains of pain in his chest; has a hard cough, with slight muco-purulent expectoration; tongue coated; bowels regular. Physical examination gave evidence of marked disease within the cavity of the chest. Heart normal. Urine was cloudy, of light amber colour, acid, sp. gr. 1010, albumen about $\frac{1}{8}$, no sugar; it contained pus corpuscles and epithelium from bladder, but no tube casts; micturition exceedingly frequent, and urgent.

The patient grew weaker, became delirious on the day after admission, and continued in this condition until death, on the 5th day that he was under observation. His temperature was continuously subnormal, ranging from 99° F. on the day of admission, to 96.6° F., which point it reached twenty-four hours previous to death. The pulse varied from 90 to 110 per minute. The respirations averaged about 26 per minute.

The patient was at no time in a condition to give a good account either of his history or his sensations, and a complete physical examination was equally difficult.

For the clinical notes of this case, I am indebted to Dr. F. C. Hand, the Resident Physician; and for the use of the hospital clinical record, to Dr. J. Aitken Meigs, under whose charge the patient was admitted. The autopsy and its record were made by myself.

Post-mortem Record 24 hours after Death.—Rigor mortis marked; extreme emaciation. The inguinal glands on both sides were hardened and enlarged, as well as also some of them in the supra-clavicular region. A doubtful appearance, resembling an old cicatrix, was found in the left groin; there is also an old scar to be seen in the fold of the prepuce. The *cavity of the abdomen* contained a large amount of clear serum. There were no inflammatory changes.

Pleural Cavities.—The upper part of the *left* side was closed by adhesion, whilst the base of the left lung was compressed by a large inflammatory exudation, containing considerable flocculent lymph. The surface of the lung everywhere, as well as the thoracic wall, was covered by a layer of recent lymph of considerable thickness, firmly adherent to the subjacent tissues. On the *right* side, the pleural surfaces were also adherent; the characters of the adhesion indicated an older date, but in addition there was evidence of recent changes. Between the layers of fibrous tissue and lymph, were found a few patches of hemorrhage; one patch was of considerable extent.

The *pericardium* contained about f℥ij of serum, in which were found floating a few small fibrinous coagula. The *heart* presented nothing especial; its weight was 12 oz. av. The *lungs* were reduced in size, the left one being the smaller, due to the compression of the lower lobe. To the finger, they gave the sensation of greater solidity than normal, and numerous small nodules were felt. The tissue was everywhere crepitant. On section, there was seen considerable congestion and œdema, and the bronchial tubes were conspicuous. Both lungs, but especially the left, were studded with grayish granulations. Two or three cheesy masses, not larger than two peas in size, were discovered in each lung; some of them partly softened. *Bronchia:* On section of the tubes, the mucous membrane was found swollen, reddened, and uneven, covered with tenacious mucus. There was no evidence of ulceration or changes in the glands. The *glands at the root of the lungs* were blackened, some of them swollen, but none of them cheesy. The *spleen* was softened; the capsule was unchanged. In the substance of the organ were found several small, white, firm nodules, not larger than a small shot; weight, 7 oz. av. The *pancreas* was normal.

Kidneys.—Left was large and appeared a trifle swollen; the surface was mottled, and presented numerous whitish, hard nodules, similar to those in the spleen, which rendered the capsule slightly prominent. At these points the capsule was adherent, whilst at other parts of the surface it was removed with normal ease. On section, the relative proportions of the cortex and the medulla were found maintained. A half dozen white nodules were seen on the surface of the principal section; weight, 6 oz. av. The *left ureter and its pelvis* appeared normal. An examination of the *right kidney* and its *ureter*, whilst yet in position in the body, showed the kidney to be enlarged; and its ureter could be traced as a firm cord-like body, passing downwards over the brim of the pelvis to the bladder. After removal from the body, in connection with the urinary bladder, the enlargement of the kidney was found principally in its thickness; its upper part fluctuating like a thick-walled cyst; its lower end was firm, and had a whitish colour. On section, abundance of whitish-creamy material of fluid consistence escaped, containing numerous flakes of solid matter. This material occupied the pelvis, to whose walls firmer portions adhered; and numerous anfractuous cavities, having their seat corresponding to that normally occupied by the pyramids. The lower part of the organ showed but slight traces of normal structure, being mostly occupied by whitish masses, likewise corresponding somewhat to the situation of the pyramids, but also invading the cortical portions.

The *bladder* contained a small amount of clear normal-coloured urine. Its mucous membrane was uneven and injected; not only were large vessels to be seen, but the general surface was pinkish-gray (fine injection). On its anterior wall were two slightly excavated ulcerations of the mucous membrane of considerable extent, surrounded by a red injected zone, slightly elevated. On the right wall were other ulcers of smaller size. The surface of the trigonum vesicæ showed numerous firm, yellowish-white, little bodies, varying in size from a pin's head to a small shot; on the ulcerated surfaces were to be seen similar bodies, generally of very minute size. The entrance of the *right ureter* was enlarged to the size of one's finger tip, and the mouth of the tube was seen blocked by firm, cheesy material; the ureter itself was left unopened, but through its whole course was firm, uneven, and dilated fully half an inch in calibre.

The entrance of the left ureter, and in general the left side of the bladder, presented more nearly normal conditions.

The *prostate gland* was enlarged, especially its middle lobe; on section, there presented a whitish, cheesy aspect, but there was no trace of softening. The *liver* showed a number of small whitish nodules directly beneath the capsule; otherwise the appearance of the organ was normal, although rather pale.

The lower portion of the *ilium*, directly around the ileo-cæcal valve presented a tubercular deposit in the wall of the gut; the mucous membrane at this part was ulcerated, and the peritoneal surface was rough and uneven. The other portions of the intestines presented nothing especial. The *glands of the mesentery* were all either enlarged, hardened, or cheesy. The lymphatic-chain of glands, commencing at the femoral ring and extending as high as the diaphragm and into the fissure of the liver, was in the same condition; this change was more marked on the right side, in both the iliac and lumbar regions, than on the left. The glands in the hilum of the right kidney were likewise changed. The testicles were not diseased.

Remarks.—The origin and course of the disease in the first case seem pretty clearly defined; the gonorrhœal disease extended to the mucous membrane of the bladder, and from thence to the ureter. The inflammation of this tube led to swelling of its mucous membrane, thereby narrowing its calibre. The catarrhal products, not being able to make their exit into the bladder, were retained a sufficient length of time to inspissate; meanwhile, the catarrhal inflammation continued, constantly adding new products to those already retained in the calibre of the ureter, rendering the mass more dense and enlarging the diameter of the tube. The epithelial elements, by close packing, from excessive accumulation, had their vitality destroyed—a vitality, already of a low grade, which is maintained so long as they continue to float freely in the serum. The impossibility of the removal of these desquamating epithelial elements, owing to closure of the ureter, gave the opportunity for the removal by absorption of this serum—nay, we might very truly say, it is pressed out from among the epithelial elements. We have then in the calibre of the ureter a mass of cells undergoing a cheesy metamorphosis.

The backing up and retention of the inflammatory products continue until the pelvis of the kidney is filled with the same materials, and presents the same condition as the ureter, as shown by the specimen. The continuation of the process into the straight tubes of the pyramids is of a like character. When we come to the consideration of the degenerative process, which results in the breaking down of the cheesy mass, occupying the area of the pyramids, there is an additional or new effect to be considered. We are looking now at a series of fine threads of cheesy material, occupying the calibre of fine tubes; these tubes, having a columnar epithelium resting on a pretty firm basement membrane, are abundantly surrounded by arterial vessels, running in a course parallel to their length. These tubes are functioning organs of a high order, not ordinarily much affected by disease, and not very frequently exhibiting degenerative changes; certainly not such degenerative change as that pictured by cheesy metamorphosis.

In fact, from the greater vascularity of the pyramids, we should suppose a cheesy metamorphosis more likely to occur in the less vascularized ureter; in the ureter the effect was distension and stretching of its elastic wall. The foreign product now present in this tube causes, if it has any effect, a reactive inflammation, accompanied by increased vascularity, which may, as a final result, lead to such rapid cell-growth, and thereby rapid cell-death, as to present to us the picture of ulceration. Such changes, however, come only from very great distension, or the long presence of a foreign mass in a tube of such elastic nature as the ureter.

This greater vascularity of the pyramid is a cause of its more rapid destruction; the more highly vascularized organ produces epithelial elements in great abundance and with greater rapidity. The condition of the pelvis and ureter prevents the escape of these inflammatory elements. The continued production of these products tends to distend the straight tubes of the pyramid. The first effect of such a distension must be pressure on the vasæ rectæ and the exclusion of blood from the vascular pathways of the cones.

The degenerative process commences first of all in the materials contained within the tube. These tubes have long since been dead functionally; the anatomical death of the tubular wall and its vascular companion is deferred until later. The fibrous elements, the firmer structures, may be maintained concealed in the cheesy mass, and only again become visible in the subsequent softening which is impending.

The cheesy mass is now a foreign body occupying, but not displacing, the kidney structures. It has long been cut off from its source of nutrition; the cellular elements of which it is composed have had their integrity destroyed by mutual pressure. We know that the condition of softening or fluidity, which nearly constantly results in these cheesy masses, comes about by the simple addition of water to the materials present, without the further development of formed constituents. Whether it is that the shrivelling of the cell-elements and the partial absorption of the molecular detritus, by lymphatic agency, leaves a space—a vacuum, so to say—in the preformed area of the cheesy mass, into which fluid enters, and thereby brings about a solution of the remaining products; or, whether it is that these albuminous products pass over into fluid compounds directly, or perhaps into compounds which have a chemical affinity for the water or serum which is so necessary for their fluidity, remains an undecided question.

Hand in hand with the softening of the purely cheesy materials, viz., the epithelial debris, goes on also the loosening up and finally the melting down of the structures in which the cheesy matter is inclosed, as well as of the tissues immediately adjacent.

The great pressure of the accumulating materials in the tubes so enlarges the area of the pyramids that a strong compression of the cortex, both the inter-pyramidal portion, and that at the base towards the surface of the kidney, comes about. These portions are pressed together, and present, as they do in the specimen, a very thin layer, or wholly disappear. Perhaps, too, the tubes of the cortex may become filled with epithelial elements, which are finally transformed into a cheesy material. We can see the evidence of this enlargement, and of the pressure exerted by the transformed pyramids in the quadrilateral figures which their areas assume.

In the second case, the origin of the disease is less easy to trace; the defective clinical history deprives us of all opportunity of determining at which part the first symptoms were developed.

The presence of the tuberculosis of the mucous membrane of the urinary bladder points naturally, according to the common opinion, to its origin from an original tubercular deposit in that situation, or primarily in the kidney itself. It is quite possible to suppose it was at either one or the other; if the tuberculosis commenced in the kidney the extension of the disease was from above downwards in the ureter; if in the bladder the progression was upwards, as in Case I., although in Case II. the moving cause was not the same.

The authorities on the subject, who speak of this form of destruction of the kidney (phthisis renalis), mention only "an irruption of tubercle beginning at the renal papillæ;" they give no cause for such tubercular deposit, which is now almost universally conceded to have, as its anatomical basis, a cheesy mass or gland somewhere in the body. Whatever, however, is the origin of the disease, the steps in the destructive process are the same: the catarrhal process of the mucous membrane, with the accumulation of the cell elements, is a very essential complication of the anatomical picture, and it is to this part of the disease that we have to look as the basis of the destruction which so constantly follows.

What casts a doubt on Case II. having originated as a primary tuberculosis—I do not say disease—of the bladder or renal mucous membrane, is the entire absence of evidence in the body of the pre-existence of a cheesy mass, which served as the anatomical basis of the irruption of tubercle at either of these situations. The lungs, and the glands at their root, fail to show us this point of development. Everything in the post-mortem examination points to the primary development of disease at or around the kidney, or in its tube of exit, or in the bladder; most probably in the bladder, since the prostate gland is found so much changed.

If the apparently well-established pathological fact is true, that the irruption of miliary tubercle depends, for its anatomical basis, on the pre-existence of a cheesy mass, or on what I think to be an equally sufficient anatomical basis, viz., a catarrhal process whose elements, when absorbed, tend rapidly to a cheesy-metamorphosis, we are compelled to look to the bladder mucous membrane as the part furnishing these elements, as the part which was undergoing a catarrhal inflammation, and furnished to the blood the degenerating elements. What is more likely from the habits of the man, evidenced by the scar of bubo and the scar of the preputial chancre, than that this man suffered at one time a gonorrhœa, which extended to his bladder? If this supposition is admissible, both cases come under one heading.

Looking at the two cases in this light, we have a course for the disease similar to that which the English authors describe as the pathology of Surgical Kidney; we have a complication superadded to the ordinary picture of surgical kidney in the irruption of tuberculosis into almost all the viscera of the body, inclusive of the kidney itself.

The surgical kidney of the English authors, and that form of disease spoken of by Klebs under Pyelo-Nephritis (*Handbuch der Pathologischen Anatomie*, p. 654), differ materially from the cases we are now discussing. Catheterism and an infectious disease are spoken of as the causes of the surgical trouble. Klebs especially alludes to the parasitic (Bacteria) nature of the inflammation, and distinctly states that while it has its origin in the urine-conducting apparatus, there is no continuity of disease between the diseased parts, viz., the bladder and the kidney.

Roberts' Phlegmonoid Abscess of the Kidney, which is to be included under the heading of surgical kidney, certainly presents a picture differing so very widely from the clinical history and the morbid appearances of these two cases as to preclude any relationship.

Authors, so far as I am aware, do not trace the connection, certainly not the steps of the process from the catarrhal process upwards to the destruction of the kidney, with the degree of vividness commensurate with the importance of the disease.

Rokitansky (*Path. Anat.*, vol. ii. p. 208, Syd. Soc. Translation) says, in speaking of this form of (so-called) tubercle of the kidney, that the disease (viz., tubercle)—

> "Generally attacks the testes, prostate, and the lymphatics primarily, and extends from these to the urinary apparatus . . . is commonly viewed as possessing a blennorrhœic character, or as gonorrhœal tubercle; but post-mortem examinations have not established the fact by demonstrating any peculiarity in the tubercular deposit. . . . The disease generally attacks one kidney only in a very extensive degree."

Rokitansky, in disregarding the "blennorrhœic" origin of the disease, at least as one of its modes of origin—it is certain that it is not the sole mode—sought for the evidence of its gonorrhœal dependence in the wrong place. No one, now-a-days, would expect to find differential characteristics in the histology of a tubercle resulting, say, on the one hand, from catarrhal disease of the lung, or on the other hand, from the inoculation of tubercular matter in the connective tissue of an animal. Neither was Rokitansky aware of the power that a catarrhal inflammation has of causing the formation of cheesy masses, as has been demonstrated since his time most ably by Rindfleisch, as well as by others.

Niemeyer (*Text-book of Pract. Med.*, vol. ii. p. 46) adds very little to Rokitansky's description of the kidney. He says "that it is not constantly preceded by pulmonary tubercle; but this disease almost always sets in at a more advanced period of the renal disease."

This second form, he says, is not easy of positive diagnosis, but may with great probability be suspected; its existence receives confirmation if we are able to feel an uneven tumour in the region of the kidney, taken in connection with the occurrence of pus in the urine in the course of a chronic disease of the urinary passages, with now and then blood in the secretion, and the coexistence of an enlargement of the testicle.

Dr. Wm. Roberts (*Urinary and Renal Diseases*, p. 457–467) speaks of this form of kidney disease under the heading of "Primary Tubercle of the Kidneys (Tuberculous Pyelitis)." He states that the disease begins in the kidney, but that it always implicates more or less extensively the excretory apparatus, and extends *downwards* towards the bladder. His description of the kidney is the counterpart of that presented by these two specimens. He says of the pelvis and ureter that "the (tuberculous) deposit begins in the submucous cellular layer," and that this deposit, as well as the mucous membrane, subsequently undergoes the changes ordinarily described. He mentions the closure of the ureter by "this deposit" in the tube. "The disease very rarely runs its entire course without the occurrence of tuberculous deposits in other and unconnected parts of the body."

Dr. Roberts gives a case which he himself examined, and quotes another from the clinique of Prof. Kussmaul of this form of destruction of the kidney, which undoubtedly did not "begin in the kidney" (judging from their clinical histories), as he declares such cases of tubercular kidney do begin. The course of the disease in the two cases which he cites approximated closely to the two cases here given; Dr. Roberts's case was of longer duration than either of my own; further, it would seem to be not unlikely that it might possibly be of calculous origin, as a quantity of earthy matter was found. Passing over the question of the origin of the disease, there appears to me evidence that the trouble commenced in the bladder and extended upwards through the ureter to the kidney. Kussmaul's case gives a distinct statement of its origin in a cystitis in a patient who "took cold in consequence of a severe wetting." Such a clinical history is not in accordance with a tubercular disease of the urinary passages or with a deposit of tubercle in the kidney itself. In this case, the evidence of tuberculization does not come until the lapse of six months from the initial bladder disease.

The method of formation of the so-called primary tubercle of the kidney, which I have given as the result of the examination of these two cases, differs materially from the general and accepted views of this change in the renal organs. The statements that have been put forward in explanation of the morbid picture, divide themselves into two classes; the first, that the disease is the result of a deposit of tuberculous matter, primarily in the renal papillæ, and subsequently in the submucous layer of the ureter, etc.; the second, that the disease may result from the irruption or primary formation of miliary tubercular nodules in the urino-genital mucous membrane, and that an essential element in the destruction of the kidney tissues is the subsequent catarrhal complication (Rindfleisch). I have striven to show why neither of these views is a satisfactory explanation of these cases.

What I wish to render prominent is that the catarrhal process is a pre-existent factor; pathological anatomy does not recognize anything that can be called tubercular, similar to the materials here found occupying the ureter, the kidney, and its pelvis; that the products here found are essentially catarrhal in their origin; that, so long as our present theories of tuberculization hold, the tubercular deposit (miliary nodules) found in the genito-urinary mucous membrane must have, as their anatomical basis, a pre-existent cheesy mass somewhere in the body.

Finally, I think that what we are taught by these specimens is that this is a catarrhal—not pneumonia, for we are dealing with a kidney—nephritis; that this chronic catarrhal disease can cause, by softening, a vomica in the renal tissue; and that the cheesy-metamorphosed mass is, or the catarrhal products themselves alone may be, the anatomical basis of the infection of the system with miliary tubercle—the same picture which we see so frequently in catarrhal disease of the lung.

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ARTICLE VI.

SYPHILIS OF THE LUNG. By L. McLane Tiffany, B.A. (Cantab.), M.D., Professor of Operative Surgery in the University of Maryland.

THE occurrence of syphilitic deposit in the lungs of adults under the form of gummy tumours is at the present time a well-recognized condition. The occurrence of a diffused gummy deposit, an interstitial pneumonia capable of running into syphilitic phthisis, is not so well appreciated in either its ante- or post-mortem language. The following cases appear to be examples of this latter form of disease. The microscopic appearances have revealed nothing distinctive to my eye; on the other hand, the macroscopic aspect is very striking, and in two cases (4 and 5) of those reported led to a careful search for, and a discovery of, the syphilitic antecedents:—

CASE 1.—M. C., æt. 23 years, negress, inmate of Baltimore City Almshouse; first seen March 14, 1876; at this time was nursing her child, a baby aged six months. Child was suffering from congenital syphilis, and died one month later. Autopsy of child showed several gummy tumours in each lung. M. C. had been taking no syphilitic remedies. There were both on body and limbs remains of a squamous